

OPERATION FOR COMPLETE PROLAPSE OF THE
RECTUM AFTER THE METHOD RECOM-
MENDED BY DR. JOHN B. ROBERTS,
OF PHILADELPHIA.

By JAMES BELL, M. D.,

OF MONTREAL,

SURGEON TO THE MONTREAL GENERAL HOSPITAL AND LECTURER IN CLINICAL
SURGERY M'GILL UNIVERSITY.

IN THE ANNALS OF SURGERY for April, 1890, (No. 4, vol, xi)
Dr. Roberts described an operation which he had performed for complete prolapse of the rectum, and which had yielded a most satisfactory result. The details of the operation, which the author described as "probably new," and the report of the case operated upon, arrested my attention partly from its apparent feasibility, but chiefly for the reason that I had at the time in my hospital wards a very bad case of complete prolapse, which seemed to me to be utterly irremediable by any method of operating then known. It is therefore with the object of putting this case on record in support of Dr. Roberts' operation that I submit this communication. As the operation is fully described in the article referred to, and also in Dr. Roberts' "Manual of Modern Surgery," recently published, I shall content myself with stating that it consists in the "removal of V-shaped portions of the sphincter and of the entire posterior wall of the rectum." The following is a brief report of the case:

F. C., a somewhat anæmic, but otherwise healthy young woman, a seamstress, æt. 22 years, suffered from prolapse of the rectum to such an extent that simply standing in the erect position or at most a walk of twenty paces would cause the bowel to protrude in a conical mass

of from four to six inches in length. The history of the onset of this trouble is somewhat obscure, but the main facts are these: At the age of ten years she suffered from a fall upon her back from a height of about ten feet. There is no history of paraplegia, but the accident was followed by incontinence of urine, and after about two years by diarrhoea, which lasted more or less constantly for five or six years. About five years prior to her admission to hospital the bowel began to protrude at stool, but was easily returned. The tendency to prolapse grew gradually worse, until it reached the condition already described. The incontinence of urine had persisted and she had also very imperfect control of the sphincter ani, especially when the bowels were at all relaxed and practically no control when diarrhoea existed. There was also loss of sensation over the buttocks and posterior surfaces of the thighs and calves, although there was no paralysis of the muscles of the lower extremities. On examination, with the patient on her back in a horizontal position with the thighs flexed upon the abdomen, the sphincter was seen to be relaxed and lying open, so that drawing the buttocks aside caused it to gape widely. Indeed, it had so little contractile power that a man's hand, of ordinary size, could be easily introduced. The prolapse seems, therefore, to have originated in paralysis of the sphincter, due to the special injury received twelve years previous to coming under observation. On May 22, 1890, the bowels having been thoroughly evacuated, the patient was anæsthetized and a V-shaped piece was removed, having its apex at the point of the coccyx, and its base consisting of the posterior part of the sphincter ani from an inch and a half to two inches in length. Another V was then removed from the posterior part of the rectum throughout its whole thickness having for its base the same portion of the sphincter and its apex about four inches up the bowel. The bleeding was free, but not troublesome nor alarming. The wound in the bowel was closed by interrupted sutures of fine silk tied within the bowel. The separated ends of the sphincter were brought together by two strong silk sutures and another was inserted just below it. A drainage tube was introduced at the point of coccyx and carried up behind the line of suture in the rectum. For eight days there was a considerable degree of inflammatory reaction with a temperature varying from 99° F. to 101° F., and on one occasion, only reaching 102° F. After the eighth day the temperature remained normal and the patient was free from pain. The sutures were then removed from the sphincter and the drainage tube withdrawn, when a small sinus was discovered, leading from the bowel just within the sphincter to the opening which had been occupied by the drainage tube and through

which some faecal matter passed in defecation. The patient had an excellent and uninterrupted recovery, and six weeks after the operation was allowed up. She was discharged on August 13, a little less than twelve weeks after operation, in better health than she had known for years, much better control of the sphincter and no longer any escape of faeces from the wound, although a small sinus still existed at the front of the coccyx through which a fine probe could be passed into the rectum just above the sphincter. This patient, at my request, again presented herself for examination on October 28. The wound had then completely healed, the control of the sphincter was good—much better than before operation, and the general health excellent. She stated that for two months she had been actively engaged in doing housework, going up and down stairs, etc., and that no sign of prolapse had ever been observed.

Such cases as the above are fortunately rare, but when met with I cannot think that cauterization, linear excisions, or even amputation (partial or complete), can prove an effective remedy. Ventral fixation of the sigmoid flexure, as carried out and described by Brigade Surgeon McLeod, of Calcutta, seems to have given satisfactory results, although there are theoretically heavy objections which might be urged against it. The operation recommended by Dr. Roberts, however, is sound in principle as well as safe and simple in practice, and as far as one can be justified in drawing conclusions from two cases, it seems to leave little to be desired.